MENTAL HEALTH SERVICES PLAN
PROVIDER ENROLLMENT ADDENDUM

Montana Medicaid Provider Number: _____

The individual or entity identified below has applied for enrollment and is enrolled as a provider in the Montana Medicaid Program ("Medicaid"), and has also requested enrollment as a provider under the Mental Health Services Plan established in ARM Title 46, Chapter 20 (the "Plan").

In consideration of enrollment in the Plan and Plan payments made to the Provider for covered medically necessary services under the Plan, the Provider acknowledges and agrees to the following:

As a condition of participation in the Plan, the Provider must be and remain enrolled as a Medicaid Provider. Participation in the Plan shall be limited to the category or categories of services which is a covered service under the Plan and for which the Provider is enrolled in Medicaid.

The Provider agrees to comply with and be bound by all applicable laws, regulations, rules and written policies pertaining to the Plan, and those Medicaid laws, regulations, rules and written policies applicable under the Plan, including but not limited to the Montana Code Annotated, the Administrative Rules of Montana and written policies of the Department of Public Health and Human Services (DPHHS).

DPHHS is authorized to use the information contained in the Provider's Medicaid Provider Agreement for purposes of administering the Plan. Provider acknowledges and agrees that the provisions of the Medicaid Provider Agreement shall apply to the Plan as if the Plan services were Medicaid services, except that this Addendum shall not be construed to make applicable to the Plan any provisions of State or Federal laws, regulations, rules and policies not otherwise applicable to the Plan.

Enrollment in the Plan under this Addendum shall be effective according to the same provisions applicable to Medicaid enrollment under ARM 46.12.302. This addendum shall terminate, without affecting the Provider's Medicaid Provider Agreement, upon written notice by DPHHS to the Provider or upon the termination of the Plan.

This Addendum shall be a part of the Provider's Medicaid Provider Agreement for purposes of governing the Provider's participation in the Plan. However, this Addendum shall not in any way reduce or modify the Provider's obligations under the Provider's Medicaid Provider Agreement with respect to participation or provision of services under the Montana Medicaid Program.

Individual Practitioner Name Printed	
Individual Practitioner Signature	Date
or for facilities and non-practitioner organizations:	
Authorized Representative Name Printed	Title/Position
Address	Telephone Number
Authorized Representative Signature	Date